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ABSTRACT

Behavioral scientists are becoming increasingly involved in the field of medicine. This paper describes some of the issues that can arise when the behavioral scientist collaborates with the medical practitioner. Recommendations are offered for the behavioral scientist considering such collaboration. (Author/VG)

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Counseling Applications in Medical Settings: nseling Skills for Residents in Family Practice[1]

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Behavioral scientists are becoming increasingly involved in the field of medicine. Clinical and educational psychologists in particular have begun to collaborate with physicians to pursue the common goal of improving the quality of patient care. This collaboration has taken several forms. For example, in the cardiovascular disease area, psychologists are exploring the role of psychosocial factors in the disease process, investigating the influence of psychosocial variables in medical treatment, and examining lifestyle behaviors that may be precursers or contributors to illness (Enelow & Henderson, 1975; Weiss, 1975). The results of these initial efforts to integrate behavioral science and medicine indicate that this collaboration holds considerable promise and apparent benefit for all concerned. It appears that a holistic approach to human behavior in the medical setting that attends to both the psychological and the somatic may, at long last, be occurring.

As exciting as these developments appear, however, considerable debate and discussion occurs when the behavioral scientist enters the medical arena. The purpose of this paper is to describe some of the issues that can arise when the behavioral scientist collaborates with the medical practitioner. Recommendations will be offered for the

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behavioral scientist considering such an endeavor.

Counseling Skills for Physicians

Counseling skills are fundamental to medical practice. The physician relies on his ability to establish an open, trusting relationship with the patient in order to initiate and maintain quality patient care. The physician must establish rapport with the patient to obtain accurate information about the patient's symptoms in order to perform an accurate diagnosis. In addition, physician-patient rapport increases the effects of patient educational efforts. Physician-patient rapport also increases the probability of the patient's participation in treatment and rehabilitation regimens. Moreover, however, physician-patient rapport is important since, from the patient's perspective, the successful medical treatment results not only in the reduction or absence of pain and discomfort, but also in a feeling of well-being for the patient (Enelow & Swisher, 1972).

The importance of rapport in the physician-patient relationship is not a new concept in Medicine. References to a physician's "bedside Manner" are often heard, and considerable literature is available exhorting the physician to attend to the interpersonal aspects of medical practice. It has only been within recent years, however, that specific abilities have been identified for establishing rapport (Enelow, Adler, & Wexler, 1970; Garret, 1967; Arsham, Gould, Russell, & Weinstein, 1976). Examples of these abilities are:

1. "The health professional demonstrates 'active listening' by using a combination of statements including:
    a. clarification
    b. confrontation
    c. facilitation"

2. "The health professional communicates (both verbally and nonverbally) a realistic interest in the patient's problems and a willingness to help."

3. "The health professional can differentiate empathy from sympathy."

Recently, behavioral scientists working in the cardiovascular disease area have underscored the influence of the quality of the physician-patient relationship on the treatment process. Studies indicate that physician-patient rapport strongly influences the degree of patient adherence to prescribed medication regimens (Hulka, 1976). Additionally, specific behaviorally based techniques developed in clinical psychology have been found to significantly reduce the incidence of patient nonadherence (Caplan, Robinson, French, et al., 1976; Sackett & Haynes, 1976).

The introduction of counseling skills and behavioral based techniques into medical practice offers the opportunity for a collaborative effort between behavioral scientists and medical practitioners to improve the quality of patient care. However, it has been my observation in working with physicians over the past few years in several medical settings, that availability alone of valid counseling skills that are appropriate for the medical setting does not insure their usage. A major additional effort is required to gain the acceptance of these techniques by the physicians, and to initiate educational activities that will teach these skills to the medical student and resident.

Faculty Reaction to Training in Counseling Skills

Physicians have had mixed reactions to the suggestion of providing medical students or residents with training in counseling skills and

behavioral techniques that are designed to promote patient adherence to treatment regimens. A few physicians recognize the potential importance of these skills and enthusiastically support the proposed training programs. Other physicians, however, have offered a variety of arguments in opposition.

Probably the most common argument encountered has been, "My patients are different from your patients [i.e., whatever patient population upon which the experimental data was collected]. A 'different' approach is therefore needed." For example, "My patients are general medical patients, and are therefore different from your patients who have cardiovascular disease", or, "My patients are from a small town in the Southwest, and are therefore different from your patients who came from a large metropolitan area."

This argument can be appropriate in come cases and, in fact, raises for the clinician the difficult theoretical and practical issue of the generalizability of the treatment's effect. The demonstration of generalizability of the effects of a treatment across numerous sub-populations has traditionally been absent in clinical research. Unfortunately, this argument is used "PRN" by the physician; the physician will frequently identify characteristics that have a low probability for effecting the success of the proposed counseling skills, and refuse to consider their inclusion in the training programs.

A second argument heard opposing the introduction of counseling skills and behavioral techniques into the medical setting, is that behavioral scientists who promote counseling skills are "meddling" in the physician-patient relationship; the behavioral scientist should refrain from encroaching on the physician's territory and responsibility.

This argument probably arises from several sources including:

1. The implied threat raised that the physician is not delivering quality patient care if the counseling skills are not being used by the physician.
2. The suggestion that the physician currently lacks knowledge and/or training in the counseling skills.

and, 3. The mistaken belief that a third party (the behavioral scientist) will be introduced into the physician-patient dyad to function as an intermediary.

Regardless of the source of the disagreement, scrutiny of the patient-physician relationship and the suggested inclusion of counseling skills implies a change in many physicians' self-defined role. The physician can no longer treat a patient as a "hypertensive" or a "malfunctioning heart valve" or a "kidney", the physician must also attend to psychosocial issues. This broader focus requires the physician to consider the antecedent, concurrent, and maintaining social, psychological, and environmental factors that may be interacting with the disease process. The change in role not only places increased responsibility on the physician, but also requires additional expertise. Unfortunately, many physicians feel they simply do not have the time to accept this expanded role or the opportunity to acquire the skills needed.

The resolution of the issues of increased responsibility, lack of time, and absence of necessary expertise, needs to be carefully considered. It is apparent that physicians can acquire needed minimal counseling skills through a variety of undergraduate, residency, and continuing education activities. This problem is basically one of logistics.

Regarding the issue of lack of time, counseling skills are not addi-

tional procedures for the physician to use with a patient, rather they are a replacement for the less effective methods currently used. The concern for time becomes an artificial issue, particularly in view of the probable reduction in future medical complications resulting from miscommunication with the patient, or refusal by the patient to return for follow-up visits due to an uneasiness in the patient-physician relationship. From a preventive perspective, improved counseling skills result in improved patient care with minimal (if any) additional time required.

A serious question, however, is raised by the issue of an expanded physician role. Should the physician simply be taught basic counseling skills, or should the physician receive a broader set of counseling skills and lengthier training in the behavioral sciences? Whether the physician seeks this role or not, the family physician is frequently placed in the role of counselor for marital, psychiatric, substance abuse, planned parenthood, and child-rearing problems. As part of the "primary care" role, the family practitioner can not avoid these responsibilities. Would it not be better to prepare the physician to be able to adequately manage these problems?

The third common argument raised in opposition to training of physicians in counseling skills and the use of behavioral techniques, is that the patient must take responsibility for his or her own care. This philosophical position suggests that the physician and patient each have separate responsibilities in this relationship. The physician has the responsibility for accurately diagnosing and offering appropriate medical treatment. The physician also may perform patient education and provide encouragement to the patient to follow the prescribed medication regimen.

However, it is the patient's responsibility to follow the physician's recommendations. If the patient fails to follow the prescribed regimen, the physician, while expressing concern, need not (and indeed should not) become involved. It is the patient's responsibility to participate in treatment.

The physician's philosophical position of allowing the patient to make his or her own decision regarding participation in the treatment is similar to the position that many psychotherapists hold regarding the patient's right to self-determination. If the patient makes an informed decision regarding his/her own health, it ought to be respected by the physician. However, it is fallacious to assume that nonadherence with a prescribed treatment regimen is always based on an informed decision. In fact, the literature from behavioral psychology indicates that agreement by a patient to perform a change in behavior is frequently not sufficient for the change to occur. The patient must also learn how the desired behavioral changes can be accomplished.

Returning to the argument of the patient taking responsibility for his or her own care, it seems that while the position has philosophical appeal, the physician must be careful in the applied clinical setting to adopt this approach only in the appropriate situations. The physician must be cautious before invoking this argument as a rationalization against acquiring counseling skills and behavioral techniques for use as part of the physician's repertoire of clinical abilities. It may be the patient's responsibility to adhere to the treatment regimen, but the physician has equal responsibility to teach methods to the patient that aid the patient's efforts to adhere.

Discussion

The behavioral scientist entering the medical setting should expect to encounter these issues and perhaps others. Whether it is the training of physicians in counseling skills or other techniques to improve the psychosocial aspects of medicine, the physician is being expected to change the methods used for the delivery of patient care. The behavioral scientist must recognize that these changes are being required, and address the problems created by change.

The implementation of change in the medical setting can be approached as one might approach a consultation problem. For recommendations to be implemented, they must not only be valid, but they also must be offered in such a manner that they are acceptable by the client. Three suggestions are therefore offered as guidelines for the behavioral scientist.

The first recommendation is that, just as the consultant should know past and present factors affecting the consultees actions, the behavioral scientist must undertand that due to the nature of medical training, many physicians overemphasize experiential observations (as opposed to empirical data). Many physicians have only their past experiences to draw from to understand human behavior. Since physicians traditionally have not been trained directly in counseling skills, they have had to acquire a proper understanding of psychosocial factors through an inductive learning process. Experience was gained from observing faculty working with patients, followed by the physician's own work with patients. Gradually through trial and error, each physician obtains a personal theory of human behavior.

The behavioral scientist, therefore, should not rely too heavily on experimental studies reported in the literature to support and justify the

implementation of counseling techniques in the medical setting. Instead, the behavioral scientist will have greater credibility by offering evidence gained from clinical experience with medical patients in a setting as close as possible to the medical setting within which the physician is operating. These experiences will have greater meaning for the physician than the research data.

The second recommendation for the behavioral scientist entering the medical setting is that the techniques offered to the physician should be as specific and clearly defined as possible. The conditions under which the technique should and should not be applied must be carefully outlined. The physician is in less need of general principles of human behavior than particular reliable methods for improving rapport with the patient. For example, the physician needs to have clear illustrations of the abilities that promote rapport, such as clarification, reflection of affect, and restatement. Simple encouragement of the physician by the behavioral scientist to increase physician-patient rapport without further explanation of how to accomplish this goal is similar to the physician exhorting the patient to adhere to the treatment regimen without offering a method for doing so.

A final recommendation for the behavioral scientist is that the emerging role of the behavioral scientist needs to be clearly explained to the physician. The behavioral scientist who enters the clinical setting is attempting to introduce skills, techniques, and methodologies that will aid in the improvement of the quality of patient care. This role is very different from the role typically assumed by the clinical psychologist who, for example, is often seen as a psychometrician who performs various psychological tests. The new behavioral scientist's role is also distinct from

the sociologist or epidemiologist who is concerned with the behavioral patterns of large groups of people. Finally, the new behavioral scientist's role is clearly separate from the psychiatrist or psychotherapist who is providing independent treatment of a patient's problems.

If the various aspects of behavioral science offered by the clinical and educational psychologist are to be successfully introduced into the medical setting, then the behavioral scientist must fully recognize the obstacles to be encountered. In addition, the behavioral scientist must also be aware of the change in the physician's and the behavioral scientist's own role that will be required. The behavioral scientist should be encouraged to undertake this endeavor, but the task must be approached carefully. It is only after these issues and difficulties have been clearly identified and resolved that the interaction of behavioral science and medicine can succeed.

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